STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC	725 SOUTH SECOND ST BOONVILLE, IN47601

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 21, 22, 23, 24, 27, 2011 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Survey team: Carole McDaniel RN TC Terri Walters RN Elizabeth Harper RN Census bed type: SNF/NF: 66 SNF: 5 Total: 71 Census payor type: Medicare: 15 Medicaid: 44 Other: 12 Total: 71 Sample: 15 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective July 27, 2011 to the annual licensure survey conducted on June 21, 2011 through June 27, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0176 SS=E	Quality review 6/29/11 by Suzanne Williams, RN An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to ensure 6 of 7 residents at the Group Resident Interview meeting who indicated self administration of medications and 1 of 1 resident randomly observed self administering medications, had been determined safe by the interdisciplinary team to do so. Residents #61, #75, #76, #77, #78, #79, #80, Findings include: On 6/22/11 at 8:15 A.M., Resident # 61 was observed to be alone in his room. He was observed to have a large green pill in his mouth which he was having difficulty swallowing. He removed it from his mouth twice to reposition it in an attempt to swallow it. The green coating of the pill was dissolving. He indicated he had to get it "lined up just right." He indicated the nurse had "given me my pills to take and this one is left yet." He indicated it was the nurse's practice to leave the pills with him to take by himself. On 6/22/11 at 9:30 A.M., RN #1 indicated the resident usually had no trouble taking	F0176	**F176 It is the practice of Transcendent Healthcare of Boonville to assure that only those residents deemed appropriate per the assessment self-administer medications.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #61 no longer self-administers medication. The additional residents cited including #75, #76, #77, #78, #79, and #80 are not specifically known to the facility. However, all residents have been re-assessed and are not allowed to self-administer medications unless the assessment identifies that they are capable and they express a desire to self-administer medications. ***Other residents that have the potential to be affected have been identified by:*** All residents have been re-assessed related to self-administration of medication. Only if they have been deemed capable and express a desire ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All residents will be assessed at the time of	07/27/2011

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	medication so had elected to leave his medication for self administration. On 6/24/11 at 10:40 A.M., the Resident Group Interview was held. As residents arrived at the meeting, the Activity Director characterized each one as being alert and oriented. At the meeting, 6 of 7 residents indicated their routine medications were regularly left at the bedside, for self administration, by nurses. Resident #77 stated, "Well, she knows I'll take them." Resident #79 stated, "That helps them out (referring to the nurses)." Residents #75, #76, #78, and #80 gestured or signaled agreement with the two residents' comments. On 6/24/11 from 1:00 P.M., to 1:40 P.M., the clinical records of the six residents at the group meeting and Resident #61 were reviewed. Resident #61 did have a 9/25/08 physician order for Oyster shell calcium D 500 mg twice daily. Documentation was lacking for all residents to indicate they had been determined to be safe for self administration by assessment of the interdisciplinary team. Documentation was also lacking of a physician order for self administration of medications. Interview with the Director of Nursing Services, on 6/27/11 at 10:45 A.M.,		admission to the facility related to self-administration of medication. If a resident is deemed capable and expresses a desire to self-administer medication they will be assessed quarterly or if there is a change in condition. The nurses and QMA's have been in-serviced related to assuring that when they are administering medication, that it is the their responsibility to assure that the residents receive their medication appropriately and that it is not left at bedside unless the resident has been deemed capable and has expressed a desire to self-administer and such is supported by a physician's order. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents (if applicable) that self administer medications. In addition, the tool will observe for any medications left at bedside by nursing personnel for those residents that per the assessment do not self-administer medication. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with	

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	indicated there were three residents with physician orders for medications to be left at the bedside who were not involved in the findings above. On 6/27/11 at 3:00 P.M., the undated Policy and Procedure for Self-Administration of Medications was reviewed. Section C. indicated: The interdisciplinary team determines the resident's ability to self administer medications by means of a skill assessment conducted on a quarterly basis. Section D indicated "The results of the interdisciplinary team assessment are recorded in the resident's medical record." 3.1-11(a)		recommendations as needed. ***The date the systemic changes will be completed:*** 7-27-11	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders and obtain laboratory results and notify the physician in order to apply the	F0282	**F282 It is the practice of this facility to assure that the residents' care plans are followed appropriately in accordance with the assessed**	07/27/2011

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	protocol to adjust the resident's Coumadin dose accordingly, for 1 of 2 residents records reviewed for lab work and Coumadin orders in a sample of 15. Resident # 9 Findings include: Resident # 9's record was reviewed on 6/23/11 at 2:00 P.M. During review of the clinical record it was noted that the resident took the medication, Coumadin (blood thinner), and a lab test for PT/INR (blood clotting studies) was completed on 5/19/11. The results were reviewed with the physician. Orders were received, according to the physician's Coumadin protocol, to change the Coumadin dosage and to recheck the PT/INR on 5/26/11. The lab results for the PT/INR due on 5/26/11 were not found in Resident # 9's chart. The lab was called, and results of the lab work were provided from the Assistant Director of Nursing on 6/23/11. The copy of the 5/26/11 PT/INR results was faxed to the facility at 3:51 P.M. On 6/23/11 at 11:40 A.M., review of the Coumadin protocol of the resident #9's physician indicated: 1. If INR is 2.0-3.0, resume same dose, recheck PT/INR in 2 weeks. 2. If INR is less than 2.0, increase		**needs. This includes follow-up** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #9 laboratory results were received during survey and the physician was notified. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that any ordered laboratory results have been received that the physician has been notified of the results. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be reviewing all laboratory orders to assure that the labs were drawn in accordance with the physicians' orders and that results were received and the physician was notified of the results in a timely manner. The lab tracking form has been revised and will track routine labs and well as any newly ordered labs to assure lab results are received and the physician is notified of the results. The nurses have been in-serviced related to the revised lab tracking form and the importance of notifying the physician of any lab results obtained. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance	

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	Coumadin dose by 1 milligram per week, re check PT/INR in 1 week. 3. If INR is greater than 3.0, decrease Coumadin dose by 1 milligram per week, recheck PT/INR in 1 week. 4. If INR is greater than 4.0, hold Coumadin and call, DO NOT FAX unless greater than 4.0. On 6/24/11 at 3:00 P.M., an interview with the Director of Nursing and the Assistant Director of Nursing indicated the facility had other physician's protocols for Coumadin lab PT/INR results. The protocol for the residents physician was to change the Coumadin dose according to the INR results. The lab results for the PT/INR were lacking follow up from both the protocol and the physician. 3.1-35(g)(2)		Improvement Tool has been initiated that will be utilized to randomly review 5 residents' laboratory orders with correlating results to assure that labs are followed through appropriately. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** 7-27-11	
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure pressure sores were promptly identified	F0314	**F314 It is the practice of this facility to assure that the all residents receive the**	07/27/2011

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	and treatment initiated for 1 of 5 residents reviewed for pressure sores in a sample of 15. Resident # 22 Findings include: Resident #22's clinical record was reviewed on 6/21/11 at 2:40 P.M. His current Minimum Data Set Assessment (MDS) dated 5/13/11, indicated a moderate cognitive impairment, and extensive assistance of one staff needed for transfers, ambulation, and bed mobility. This MDS indicated the resident was at risk for pressures but had no pressure sores. His diagnoses included, but were not limited to: small cell lung cancer and type 2 diabetes. A " Braden Scale- for Predicting Pressure Sore Risk" assessment dated 5/30/11, indicated a total score of 16, with a total score of 12 or less indicating a high risk. His current care plan addressed the problem of potential for impaired skin integrity (initiation date of 5/13/11). Interventions included, but were not limited to: pressure reducing devices to chair and bed, apply protective barrier after incontinence as needed, assist resident to turn and reposition frequently as needed, monitor skin weekly, and report any skin breakdown to physician.		**necessary care and services to prevent and treat pressure ulcers.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #22 has an appropriate treatment in place and the area is improving. ***Other residents that have the potential to be affected have been identified by:*** A house-wide review has been conducted to assure that any resident that has altered skin integrity has been addressed. All residents that currently have pressure ulcers have been reviewed to assure that proper treatments and services are in place to assist with the healing of wounds. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced related to the prevention and/or of pressure ulcers. The in-service includes assuring that treatments are obtained immediately at the earliest sign of skin breakdown. All nursing staff has been in-serviced related to identifying altered skin integrity and the proper reporting mechanisms. In addition, the nurses are completing a skin assessment weekly on all residents. ***The corrective action taken to monitor performance to assure compliance through quality***	

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	On 6/22/11 from 7:42 A.M., to 12:42 P.M., Resident #22's care was observed. On 6/22/11 at 8:25 A.M., CNAs # 1 and #2, indicated they will provide incontinent care. During incontinence care, an open area of the coccyx was observed a stage 2, but unable to approximate measurements at this time. During interview with CNA #1 at this time, she indicated this open area was recent and the nurse was aware of the open area. After incontinence care was provided, the resident was repositioned in bed lying on his back (coccyx area). On 6/22/11 at 10:35 A.M., CNA s #1 and 2 were to again provide incontinence care. During incontinence care the open area of the coccyx was observed with a dark and /or bloody drainage and a reddened area stage 1 of the left buttock area. CNA #1 looked at the bedside for barrier creme and was unable to find it. She indicated she would talk to the nurse about the barrier creme. After incontinence care, the resident was again repositioned on his back (coccyx area). Documentation was lacking of physician notification of the coccyx open area until 6/23/11. Nursing notes dated 6/23/11 at 7:55 A.M., indicated, " This nurse notified by CNA		***assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to observe for the provision of wound care, assuring that treatment was obtained timely and to assure that the physician/family were notified appropriately. The tool will randomly review 5 residents (if applicable) to assure that proper interventions are in place related to the preventions and/or treatment of pressure ulcers, that treatments were obtained timely, and that the physician/family were notified timely. Nursing Administration, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July 27, 2011	

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	resident has open area on coccyx. This nurse assessed resident...." Nursing notes dated 6/23/11 at 8:05 A.M., indicated, "This RN notified Dr. (physician's name) of resident's change in condition. Resident refused breakfast; updated w/(with) wounds. Received new orders: 1. apply collagen gel to open area on coccyx. Cover w/foam dressing. Change dressing daily & prn (when needed). 2. Low air loss mattress to bed. 3. Apply barrier cream to coccyx q (every) shift & prn...." Nursing notes dated 6/23/11 at 9:00 A.M., indicated "...#1 Wound-coccyx measures 2 cm x 1 cm x 0.1 cm with small amount of serous drainage. Wound edges are rolled. Wound bed is pink. Staged at a stage II area on coccyx. Wound #2 now measures 2 cm x 2 cm to the left of the coccyx. No drainage or odor noted. Area is pink & blanchable. Wound has center area that is red & blanchable measuring 0.3 cm x 0.2 cm. Area at 9 o'clock that is red & blanchable measuring 0.5 cm x 0.5 cm entire wound bed is pink & blanchable. Stage I pressure area. Wound is irregular in shape...." The facility policy section: "Pressure Wound Prevention Program" (8/13/99 original date) was received on 6/24/11 at			

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	10:20 A.M. This policy included but was not limited to: "...2. The nursing assistant documents observations of any bruising, skin tears, abrasions or other abnormalities on the Body Diagram Tool. a. Observations are reported to the licensed nurse. b. A shower day is preferable as all skin services are easily visualized...." On 6/24/11 at 11:55 A.M., the Director of Nursing (DON) was made aware of pressure ulcer observed on 6/22/11. On 6/27/11 at 8:00 A.M., during interview with the Director of Nursing (DON) in regard to Resident #22's pressure area observed on 6/22/11, but staff not reporting until the next day on 6/23/11, the DON indicated she would expect CNAs to report any skin change on shower day or any day. 3.1-40(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure side rails were consistent with the FDA (Food and Drug Administration) guidelines for safety regarding entrapment	F0323	**F323 It is the practice of this facility to assure that residents that utilize side rails are assessed properly and that the side rails are spaced**	07/27/2011

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	prevention for 23 beds of 56 total beds with side rails in the facility. These were beds in rooms: 6 A, 9 A, 11, 13, 14 B, 18 B, 19 B, 20 A, 21 B, 25, 26 B, 26 A, 27 B, 28 B, 29 B, 30 A, 32 A, 32 B, 33, 35 A, 35 B, 36 A and 36 B. Findings include: On 6/21/11 at 10:00 A.M., the facility was toured with maintenance staff #1 who measured the space between the bars of the side rails of the resident beds. The following resident beds were observed to have 1/2 side rails with space between the bars which measured 7 and 3/4 inches and 5 and 3/4 inches. These resident beds were in resident rooms: 6 A, 9 A, 11, 18 B, 19 B, 20 A, 21 B, 25, 26 B, 26 A, 27 B, 28 B, 29 B, 30 A, 32 A, 32 B, 33, 35 A, 35 B, 36 A, and 36 B. On the 6/21/11 10:00 A.M., tour with maintenance staff #,1 the side rails in resident room 13 were measured as space between the bars of 8 and 1/2 inches and 10 inches. The Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings		**appropriately to assist with the prevention of any incidents related to side rails.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Rooms 6A, 9A, 11, 13, 14B, 18B, 19B, 20A, 21B, 25, 26A, 26B, 27B, 28B, 29B, 30A, 32A, 32B, 33, 35A, 35B, 36A, and 36B have all been reviewed to assure that measures are in place related to safety regarding entanglement prevention. For those residents that continue to utilize side rails, either a bolster device is in place or the side rail has been covered with a mesh side rail cover to promote safety if the actual rails themselves do not meet standard. ***Other residents that have the potential to be affected have been identified by:*** All residents that utilize side rails have been reassessed. All residents that utilize side rails have had bed bolsters applied or a mesh side rail cover to promote safety.***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Side rail assessments will be completed on admission, quarterly, or if there is a significant change for all residents. The implementation of the side rail bolsters or mesh covers was in place prior to the end of survey. As part of the systematic change, if an	

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TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC	725 SOUTH SECOND ST BOONVILLE, IN47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The "Hospital Bed Safety WorkGroup (HBSW)" and the "International Electrotechnical Commission (IEC)" along with the FDA recommend the space be less than 4 3/4 inches. The FDA recommends the space under the rail-at the ends of the rail be small enough to prevent neck entrapment. The HBSW and the IEC along with the FDA recommend this space be less than 2 3/8 inches and greater than a 60 degree angle. On 6/21/11 at 10:07 A.M., during tour with the maintenance staff #1, he indicated he was aware of the problem with the side rails in regard to the potential for entrapment. He indicated he had received the covers for the side rails the day before yesterday. He indicated that the covers would be applied to the side rails by the end of the day. 3.1-45(a)(1)		assessment identifies the usage of a side rail, the side rail will either be within acceptable measurement guidelines, or a side rail bolster or mesh cover will be utilized. The staff has been in-serviced related to the use of side rails and their safety. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement tool has been established that randomly reviews residents who utilize side rails to assure that they are safe and within acceptable guidelines. These tools will randomly review 5 residents. The Director of Nursing, or designee, will complete the tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tools at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** July 27, 2011	